WISCONSIN

DEPARTMENT OF WORKFORCE DEVELOPMENT
Division of Economic Support
Bureau of Work Support Programs

TO: **Economic Support Supervisors**
Economic Support Lead Workers
Training Staff
Child Care Coordinators
W-2 Agencies

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File: 1115
1120

Date: 06/21/2001

Non W-2 [X] W-2 [ ] CC [ ]

PRIORITY: High

SUBJECT: **MA PROGRAM SIMPLIFICATION (REDUCED VERIFICATION) & CLIENT CHOICE OF APPLICATIONS**

CROSS REFERENCE: **Income Maintenance Manual**, I A & B

EFFECTIVE DATE: July 1, 2001

PURPOSE

This memo implements Medicaid (MA) program simplification, including:

1. Client choice of application method for Family Related MA
2. Reduced verification requirements for all MA

BACKGROUND

Wisconsin moved to a more simplified process for application and reduced verification for several reasons:

1. Existing federal flexibility allows us to simplify the program for clients and local agency staff.

2. Advocacy groups, health care providers, local social service agencies, and our clients requested and encouraged program simplification.

3. We were further along with welfare reform, which freed the state from the program constraints of the old AFDC program and allowed us to design a more client friendly process.
4. Health care access has received bi-partisan support in Wisconsin which allows for more flexibility to simplify the program.

5. The 1115(a) demonstration program waiver of Title XXI law and regulation allows Wisconsin to receive SCHIP funding for parents in BadgerCare requires Wisconsin to eliminate the asset test for Family MA and to implement a simplified application process.

6. 40 other states have adopted a simplified application process. Many of these states have also reduced verification and adopted a mail-in application process.

7. Under reported income by clients seldom causes a loss in eligibility because income limits are high.

CURRENT MA POLICY AND PROCESS

Current policy requires that all applications for MA be done through a face-to-face interview, except for those done through the OBRA outstationing provisions of the Social Security Act. An individual applies by going through an automated interactive interview with an eligibility worker at a local agency or outstationed eligibility worker site. The application must be signed in the presence of an agency worker. The staff at a Federally Qualified Health Center (FQHC) or Disproportionate Share Hospital (DSH) can sign the application as a witness instead of an ES agency staff person. Mail and phone reviews are currently allowed for all of MA, but the choice of review method rests with the local agency staff; not the client.

The definition of questionable seems to include any time that a worker has any suspicion that the information provided is not true. Although we are not changing the definition of questionable as provided in the Income Maintenance Manual, we expect eligibility workers to follow this definition more closely than appears to have been the case in the past.

NEW POLICY & PROCESS – APPLICATION CHOICE & REDUCED VERIFICATION

APPLICATION AND REVIEW PROCESS FOR MAIL/PHONE APPLICATIONS & REVIEWS

Beginning July 1, 2001, any applicant/recipient has the option of choosing how s/he will apply for Family MA.

NOTE: The mail in choice of applying for MA is limited to Family MA at this time. A new, simplified application form is being developed for the elderly, blind and disabled population. That form will be released at a later date.

Family MA for these purposes is defined to include any person who is a caretaker relative of a child, a parent residing with a child under age 19, a child under age 19 or a pregnant woman. In addition, the client will now choose the method for his/her review. This is no longer an agency choice. The 3 choices that the client has are:

1. Face to Face Interview for Application/Review
2. Mail-In Application/Review
3. Phone Application/Review

At the time of the initial telephone or other contact, the agency must complete Client Registration, including the priority services determination. (We'll discuss how to set the filing date for phone and mail applications in their respective sections).

The economic support agency must inform any applicant/recipient wishing to apply for MA or due for a review that these choices exist. The agency should also inform these applicant/recipients that the choice of mail or phone-in effectively eliminates a choice of W-2, Child Care (CC) and Food Stamps (FS) eligibility for them as

part of this application. These all require face to face interviews. When an individual chooses the MA only phone or mail-in option for application method, a written and signed form explaining that they are 'not requesting' FS, CC or W-2 is not required, so long as the client is using the DES-2034 (NH-CAF for mail-in reviews) or the DES-12277 (Family MA for applications and reviews) application form.

WITNESSING THE SIGNATURE

For mail and phone applications, as well as reviews, the application or review form does not require an agency staff person (or a Federally Qualified Health Center or Disproportionate Share Hospital staff person at outstation sites) to witness the signature. **It does not affect our ability to prosecute for fraud or from recovering benefits provided incorrectly due to a client's misstatement or omission of fact.**

MAIL-IN APPLICATION

As of 7/1/01, only the BadgerCare and MA for Families application form (DES-12277) can be processed as a mail-in application. The filing date is the date the application form is received by the economic support agency as long as it contains the individual's name, address and signature. This starts the 30-day processing clock. Any items that are left blank should be assumed to be 'no' answers or $0.00 answers (this includes the client signing the form and not entering the date.), unless there is a reason to deem an answer 'questionable.' If a worker identifies a need for additional information, i.e. self- employment income and expense details, which is not detailed on the simplified form, a contact should be made with the client via phone or mail to obtain self-declared information. Once the additional self-declared information has been obtained, then determine if the item is "questionable." Document in case comments when the client provides any additional self-declared information from telephone or mail contact that was not written on the original mail-in application.

Review the reduced verification policies and processes portion of this memo to ascertain when an item is questionable and what documentation needs to accompany the application form.

If an individual fills out a different application form than the DES-12277 that includes only a request for Family MA (including BadgerCare) and the individual has signed a 'Voluntarily Declining Aid' form for FS, then the different application form can be handled as a mail-in application.

The new filing date policy changes the current policy for outstation sites at FQHC's or DSH's without an eligibility worker on site. Currently, the date the application is signed in front of a facility staff person becomes the filing date. This is no longer true. The filing date will be the date the application is received by the local ES agency.

If the DES-12277 is faxed to the local agency, the filing date becomes the date the FAX is printed in the local agency. The original application form is **not** required for processing. MA may not be denied because the original application was not received.

When mandatory verification materials are not returned with the application or information written on the application is confusing or contradictory, the worker should enter all information available into CARES. Then contact the client via the telephone or mail to either clarify information provided on the application or to request additional information. If mandatory verification is missing or an item is deemed 'questionable', the worker must follow-up with a written list (EEVC) of what needs to be provided and the due date for the information to be received. The client has until the end of the 30th processing day or 10 days from the request, whichever is later, to return this information. If this is not done, the worker must deny eligibility for MA based upon either failure to verify mandatory or questionable information or the failure to provide/clarify necessary information.

The eligibility worker keys in the answers provided by the client on the paper form into the CARES system.

The worker must enter 'N' on the Program Request Screens (ACPA) for FS, CC and W-2. Workers should 'key what they see' on the application form. Once data is entered into CARES, the worker should run SFED/SFEX to determine eligibility for the case and confirm. The worker should not print the CAF or send it to the client to sign.

PHONE-IN APPLICATION

At the client's request, s/he can apply over the phone. The agency must remember to complete client registration during the initial contact with the applicant.

The agency must immediately send (or otherwise make available) to the potential applicant the front page of the application form that provides a place for the client to give his/her name, address and sign the application. The filing date for the application is the date that this form (with a name, address and signature) is ***received*** by the agency. This means that no phone interactive interview can be done until the one page application sheet is returned with a name, address and signature. Along with the front application page, the agency should develop a packet of information that will assist the client in his/her preparation for the interactive interview.

This packet could include:

1. A revised version of the list of "*What to Bring With You*" (currently being developed)

2. *MA Eligibility and Benefits* brochure

3. Brochures specific to the individual if information is known about that individual (i.e. Spousal Impoverishment, MAPP, BadgerCare, etc.)

The agency must schedule a time (within regular agency hours) convenient for the client and inform the client that s/he needs to be available without interruptions for a specified period of time. The scheduling of the phone interview can occur either before or after the filing date is established.

The agency has latitude over how this process will be set up in its own agency. However, the agency's process must assure that the client is given a reasonable opportunity to connect with the worker before being considered a 'no show'.

Once connected with the client, the worker must go through the entire CARES interactive interview process. If the client wishes to apply for FS or any other program other than MA during the interview, the worker must complete the MA application, entering 'N' on ACPA for FS, CC and W-2, but also schedule a face-to-face interview with the applicant at their earliest convenience.

Once the interview is completed, the worker prints out the Combined Application Form (CAF) and sends it (or otherwise makes it available) to the applicant. The worker does not confirm eligibility for MA at this time. The applicant should review all the information provided on the CAF and make corrections.

The applicant must initial and sign the CAF on the signature page appropriately and return the form to the local agency. The applicant has until the end of the 30th day from the filing date or 10 days from the date the form is sent to him/her, whichever is later, to return the application to the local agency. If the form is not returned within this timeframe, deny the application for failure to provide information.

Then determine if the applicant made any changes to the information. If so enter these changes into the CARES System. Then determine and confirm eligibility using the CARES system. CARES will generate the appropriate approval or denial notice of decision. For cases that are determined eligible, the agency should

send out program information to the recipient that was not supplied at the initial filing of the application. This information could include such things as:

1. A fact sheet for the program for which they are eligible
2. A Change Report form
3. The Rights and Responsibilities brochure

By choosing a certain method of application or review completion the client is not tied to a specific method for completing subsequent reviews.

NEW REDUCED VERIFICATION POLICIES & PROCESSES

The following policies and processes apply to all MA subprograms and applicant/ recipients. These policies and processes apply for MA, regardless of the policy and process requirements of FS, CC and W2.

The basic tenets of MA Program verification:

1. Apply these verification instructions to all MA subprograms (BadgerCare, Healthy Start, Community Waivers, Family Care, AFDC-MA, etc.) but not to FS, CC or W-2.

2. Only verify those items required to determine eligibility and benefits.

3. If an item is not mandatory or questionable, don't verify it.

4. Do not over verify. This means requiring excessive pieces of evidence for any one item. If you have all the verification you need, don't continue to require additional verification.

5. Do not verify information already verified unless you believe the information is fraudulent or further information received now indicates that it is questionable. If you suspect fraud exists, determine if you should make a referral for fraud (IMM, Chapter II, Part D). Fraud in other programs of assistance doesn't affect MA verification.

6. Do not exclusively require a particular type of verification when various types are possible.

7. The Income Maintenance Manual defines validation as the photocopying and placing of a document in the case record and 'documentation' as making a note or comment in the case record in order to provide understanding of and accountability for case actions. For MA purposes, there is no need to validate verification, only document verification on the appropriate CARES screens.

VERIFICATION – MANDATORY ITEMS

The ES agency staff person processing eligibility must verify the following information for MA eligibility. Evertyting else is self-declared unless it is "questionable".

1. Social Security Number (SSN)

   The SSN for any person who is requesting to participate in the MA program is verified through the CARES SSN Validation Process. Any individual who fails to provide an SSN or does not agree to apply for one is not eligible for MA. An individual applying for MA does not need to provide a document or a social security card. S/he only needs to provide a number to the worker. **If the SSN validation process returns a mismatch record, then the applicant/recipient must provide the social security card or another official government document with the social security number displayed. Once an SSN is verified,**

it doesn't need to be verified again.

```
ANDA                    INDIVIDUAL DEMOGRAPHICS (2 OF 3)       06/12/01 14:45
 CASE: 0700220305                              WORKER: XCTG04    XCTG04 P KIERN
 LAST UPDATED: 10 23 00               CASE STATUS: OPEN    CASE MODE: ONGOING
                                                        ----SSN----
              DECL  LANG  US      BIRTH  DT OF          APPL
 NUM   NAME   CTZN  IND  CTZN VR  PLACE  DEATH    VR    DATE    VR   --1-  --
 01   IMA   C  Y     E    Y   OW   __   __ __ __  __  __ __ __  __     __   __
```

Field that affects SSN

2. Citizenship/Alien Status

Accept self-declaration that an individual is a citizen. The person completing the application will circle (or otherwise indicate) citizen or alien to indicate US citizen status. Any person who indicates 'alien' must provide an official government document that lists his/her alien registration number. The eligibility worker must then verify the individual's alien status by using the alien registration number and the SAVE system as described in the IM Manual. Any individual who indicates that s/he is not a citizen and then fails to provide proper verification of his/her alien registration number is ineligible, unless that individual is only applying for emergency services for non-qualifying aliens. Undocumented aliens do not have to provide an alien registration number and can still be eligible for Emergency Services only MA. Only when the client reports a change in citizenship or alien status does this item need to be verified again.

The Declaration of Citizenship form no longer needs to be signed or filed in the case record.

```
ANAR                            ALIEN/REFUGEE                    06/12/01 14:48
 CASE: 0700220305                              WORKER: XCTG04    XCTG04 P KIERN
 LAST UPDATED:                          CASE STATUS: OPEN    CASE MODE: ONGOING

 NUM: __ NAME:                                              SSN:
  DC: __ BEGIN MMYY: _____ END MMYY: _____
     COUNTRY OF ORIGIN CODE: __
              REFUGEE STATUS: _    US ENTRY DATE:  __ __
  WORK QUARTERS OR MILITARY REQUIREMENT MET? (Y/N)          VR:  __
  ALIEN REGISTRATION STATUS: __    VR: __
```

Alien status Verification

3. Pregnancy

If a woman wants to be considered pregnant for a MA eligibility determination, we must have documentation from a health care professional attesting to her pregnancy. This item needs to be verified once for each subsequent pregnancy. The pregnancy end date or the fact that the pregnancy ended is not a mandatory verification item.

```
ANPI                            PREGNANCY                        06/12/01 14:51
 CASE: 0700220305                              WORKER: XCTG04    XCTG04 P KIERN
 LAST UPDATED:                          CASE STATUS: OPEN    CASE MODE: ONGOING

 NUM: __ NAME:                                              SSN:
  DC: __ BEGIN MMYY: _____  END MMYY: _

 PREGNANCY VR: __    FETUS NUMBER: _   VR: __
```

Pregnancy verification

4. Disability & Incapacitation

Disability Any person who wants to be considered disabled for a MA, including the MA Purchase Plan, eligibility determination must have a Disability Determination completed by the Disability

Determination Bureau. This item is not verified after the original determination. There are disability reviews that are scheduled by DDB and any new information will be communicated by DDB to the Eligibility worker.

```
ANDI                          DISABILITY                          06/12/01 14:53
CASE: 0700220305                              WORKER: XCTG04    XCTG04 P KIERN
LAST UPDATED:                           CASE STATUS: OPEN    CASE MODE: ONGOING

NUM: __ NAME:                                                SSN:
 DC: __ BEGIN MMYY: ____ END MMYY: ____

HAS INDIVIDUAL BEEN ESTABLISHED BLIND BY DDB?                 (Y/N): _   VR: __
HAS INDIVIDUAL BEEN ESTABLISHED DISABLED BY DDB?              (Y/N): _   VR: __
```

Disability Verification

Incapacitation: A person who wants to be considered incapacitated for MA eligibility must provide verification from a Health Care professional attesting to the incapacitation.

```
ANIC                       INCAPACITATION                         06/12/01 14:59
 CASE: 0700220305                              WORKER: XCTG04    XCTG04 P KIERN
 LAST UPDATED:                           CASE STATUS: OPEN    CASE MODE: ONGOING

 NUM: __ NAME:                                                SSN:
  DC: __ BEGIN MMYY: ____  END MMYY: ____


 TYPE OF INCAPACITATION: __ VR: __
```

Incapacitation Verification

5. Assets & Transfers of Assets (Divestment)

Assets and transfers of assets for persons requesting and being tested for the following MA subprograms: (including community spouse assets for waiver and institutional MA at the initial determination of eligibility).

- SSI-related (categorically and medically needy)
- SSI-related Special Status – 503, Disabled Adult Child, Widow/Widowers (categorically and medically needy)
- MA Purchase Plan
- Institutional MA
- Community Waivers (unless they are Group A)
- Family Care
- Medicare Premium Assistance programs

The following is a list of the asset screens that are affected.

```
MNAI                          ASSET INFORMATION MENU          06/12/01 15:02
                                                              XCTG04 P KIERN

 FUNCTION                                    TRAN
  NUMBER    FUNCTION DESCRIPTION             CODE     PARAMETERS(PARMS)

    1   -   ASSET QUESTIONS                 (AAAQ)    CASE
    2   -   LIQUID ASSET QUESTIONS          (AALQ)    CASE
    3   -   VEHICLE ASSETS                  (AAVA)    CASE/(PIN OR SSN)/(MMDDYY)
    4   -   LIQUID ASSETS                   (AALA)    CASE/(PIN OR SSN)/(MMDDYY)
    5   -   PERSONAL PROPERTY              (AAPP)    CASE/(PIN OR SSN)/(MMDDYY)
    6   -   LIFE INSURANCE                 (AALI)    CASE/(PIN OR SSN)/(MMDDYY)
    7   -   LUMP SUM INCOME                (AALS)    CASE/(PIN OR SSN)/(MMDDYY)
    8   -   BURIAL ASSETS                  (AABA)    CASE/(PIN OR SSN)/(MMDDYY)
    9   -   REAL PROPERTY                  (AARP)    CASE/(PIN OR SSN)/(MMDDYY)
    10  -   ASSET TRANSFER/DIVESTMENT      (AAAT)    CASE/(PIN OR SSN)/(MMDDYY)
    11  -   ASSET ASSESSMENT               (AAAA)    CASE/(PIN OR SSN)/(MMDDYY)
```

VERIFICATION - QUESTIONABLE ITEMS

Other items affecting eligibility are only verified when they are questionable. The reason that the item is questionable must be documented in the Case Comments in the CARES record.
Questionable Items are those where:

1. There are consistencies in the group's oral and written statements.

2. There are inconsistencies between the group's claims and other contacts, documents or prior records. (We discuss how and when data exchange queries and reports might necessitate verification later in this document.)

3. The applicant or his/her authorized representative is unsure of the accuracy of his/her own statements.

4. The applicant has been convicted of MA recipient fraud or has legally acknowledged his/her guilt of MA recipient fraud. Do not require an applicant or recipient to verify information for acknowledging that they have been convicted of fraud in any other public assistance or employment program.

Do not require a face-to-face application or review even if s/he determines that information provided by the applicant/recipient is questionable.

POST-ELIGIBILITY VERIFICATION

Medical expenses must be verified if used to meet a MA Deductible, this will ensure the earliest certification for the client.

HANDLING DATA EXCHANGES AT INTAKE, REVIEW, PERSON ADD & ON AN ON-GOING BASIS

INTAKE / PERSON ADDS (SEE ATTACHMENT 1)

As the attached diagram indicates the Intake and Person Add driver flows both provide an on-line data exchange query. Income is considered questionable, (and therefore needs to be verified), if the data provided by the DX on-line query overlaps for a month for which MA is being requested **and** if there is a discrepancy between the income reported for the time period and the data displayed on the query of more than $1,000 for the quarterly period. In these cases, the worker must ask for verification for only the months for which eligibility is being determined which are covered by the query.

ON-GOING (ATTACHMENT 2)

As the attached diagram indicates, a worker can become aware of a discrepancy between the reported income of a case and a specific data exchange after intake between reviews in a couple of different ways. Specific data exchanges can be accessed from the MNDX menu.

1. A DXBM indicates to the worker that a new DX report has been generated. The worker then reviews the DX report to determine if any cases that are part of his/her caseload are on the report.

2. The worker receives an alert that indicates that a case that is part of his/her caseload is part of a DX report.

NOTE: In the case of #1 and #2 instances, the case would not be included on the report unless the income discrepancy between reported and the DX report was greater than the tolerance level. For example, the SWICA report only displays discrepancies that are greater than $1,000 for the quarterly period.

3. The worker uses the DX on-line query and determines if there is discrepancy between the reported data and DX query data.

In the case of DX report 'hit' or where the on-line query displays a discrepancy of $1,000 or more for the quarterly reporting period, the worker must treat the income for that period as questionable. The worker must request documentation from the client for the period covered by the DX report or query.

Using the client's verified information, the worker re-determines eligibility for the past months by entering any changes in Simulation Mode. An overpayment has occurred if the new information leads to a determination that shows any or all of the case members:

1. Are now ineligible for MA, **or**

2. There has been an increase in the group's cost share amount (nursing home liability, community waivers cost share or spenddown, deductible amount or premium amount).

The existence of an overpayment means that there was a significant change in eligibility status. The worker must process the overpayment and request verification of the current month's income, since it is now considered to be questionable.

REVIEWS (SEE ATTACHMENT 3)

As the diagram below indicates the worker must use the on-line data exchange query before beginning the review (and getting into the CARES Review Mode).

If there is discrepancy between the income reported and the DX query amount of more than $1,000 for the period, the worker needs to:

1. Run simulation for the months covered by the query using the DX query income divided by the period covered in the query to arrive at a monthly amount.

2. Income for the past period and current month become 'questionable' and therefore need to be verified, if CARES simulation shows, for any of the months run that any or all of the case members:

    a. Are now ineligible for MA, **or**

    b. There has been an increase in the group's cost share amount (nursing home liability, community waivers cost share or spenddown, deductible amount or premium amount).

If the worker determines that a significant eligibility change (as described above) exists for the past period, the worker must verify income for the past period and the current month covered by the query during the review. However, do not hold up the review while waiting for the past period.

CARES

CARES is programmed to determine what types of verification are required for different programs. So whether or not a specific verification field is used by the system, is dependent on which type of assistance group is being built (ex. MI S might check the disability verification and MA R may not). CARES has not been updated to use any verification item in eligibility determinations that it was not using before. Thus if a VR field wasn't used before, it will not be used now. In addition, there has been only one code to indicate that verification has not yet been received or is considered questionable, ("?"), and another to indicate that verification has not been provided ("NV"). Each of these codes also has impacted any and all AGs. A "?" has pended all AGs, and "NV" has failed them for reason code 112 (Short text "Did not verify information").

NEW CODES

These 2 new codes have been developed to support the changes in verification policy for MA.:

1. Q? "Questionable information and pending verification"
2. QV "Questionable information and not verified"

The new codes will be available for use on July 1st. The new codes will also be used for determining 3 month backdates. (A July 1st application with a 3 month backdate will utilize the new codes determining eligibility beginning 04/01/01.)

NEW MA VERIFICATION CODES-SUMMARY

If you enter a "Q?" or "QV" in the verification fields, you must document in case comments on CARES what criteria was used to deem the item as questionable for MA.

"Q?" Use the "Q?" if the item is considered questionable (pending verification) for MA and will work exactly like the existing ? for **all** programs of assistance. If Q? is entered **all** (MA,FS, W2, CC) programs will pend.

Only use the "Q?" code when you have a substantial reason to question the validity of the information provided by the client After entering this code, the system determines if that specific piece of verification should be used for eligibility for the particular type of AG built.

"QV" Use the "QV" code if the item was considered questionable for MA and was not verified. If "QV" is entered all programs (MA, FS, W2, CC) will fail.

Use "QV" only when you have substantial reason to question the validity of the information provided by the client, and that client has not provided that verification. After entering this code, the system determines if that specific piece of verification should be looked at for eligibility for the particular type of AG built.

"?" Use the "?" code as you did before. For the MA AG being built a "?" will:

1. Pend MA if the field being checked for that AG is a mandatory item. It will also pend the other programs (FS, W2, and CC).
2. Pass MA if the fields being checked aren't mandatory MA verification items. Entry of a "?" in any non-mandatory MA verification field will pass MA. (FS/CC/WW will pend)

"NV" The NV code should be used as it was before. If there is a verification field attached to that piece of information and the client has not provided verification within the appropriate verification period, enter a NV. A NV code will fail an MA AG if it's a mandatory verification item. If it's not a mandatory verification item, the MA AG will pass and should be confirmed.

FS/CC/WW will continue to work the same for the NV verification code, the individual will fail within those AGs if that particular AG is checking that verification field.

Verification Code	MA				Other Programs
	▪ SSN ▪ Citizenship Alien Status ▪ Pregnancy ▪ Disability	Assets for Elderly & Disabled	Assets for Family MA	All other Items	All other Items
?	Pend	Pend	Pass	Pass	Pend
NV	Fail	Fail	Pass	Pass	Fail
Q?	Pend	Pend	Pend	Pend	Pend
QV	Fail	Fail	Fail	Fail	Fail

Process cases that aren't requesting MA the same as you always have using "?" or "NV". However, if the new values ("QV" or "Q?") are used, they will work as stated above.

For MA cases (including other programs CC, W2, FS), use the new "Q?" and "QV" codes only if items are questionable.

EXAMPLES

"Q?" Example: This is a CC, FS and W2 case. An entry of "Q?" works the same way as "?." CC and W2 pend, FS passes and then fails because they are expedited.

```
ACCH                        CASE HOUSEHOLD INFORMATION            06/06/01 08:29
 CASE: 8000361485               WORKER: XCTG04  CASELOAD: 1440    XCTG04 P KIERN
 LAST UPDATED: 06 06 01                    CASE STATUS: OPEN    CASE MODE: ONGOING
 OFFICE NUM: 5040  MILW CO DSS
 SESSION CONTROL DEFAULT FOR EFFECTIVE/BEGIN MMYY: ____
 CASE FILE LOCATION: IN  LOCATION DATE: 06 15 00              FILING DATE: 06 15 00
     IVD ASSIGNMENT:                                      CASE CLOSED DATE:

                FIRST      MI       LAST          SUF   LANG IND   IN HOUSEHOLD
 IP NAME: TEEN___________ _ CMMTOCSJ_____________ ___       E            Y

                      NUMBER   UNIT DIR  ST/RURAL RT/BOX#   SUF QUAD AP
 HOUSEHOLD ADDRESS: 111_______ ___  __ W_____________________ _____ __ ___
                    ____________________________
              CITY: MILWAUKEE_______ STATE: WI ZIP: 00000____    VR: Q?
             PHONE: 000 000 0000    ALTERNATE ADDRESS (Y/N): N
 CENSUS TRACT NUM : 0001            REGION NUM: 05
 HAVE YOU RESIDED IN WI ALL YOUR LIFE? (Y/N): Y   LAST SIXTY DAYS?:  _  VR: __
 PREVIOUS WI RESIDENT? (Y/N): _                 DATE MOVED FROM WI: __ __ ____
 STATE MOVED FROM: __   DATE MOVED TO WI: __ __ ____   RES REQ MET:


 NEXT TRAN: ____     PARMS: 8000361485_____________________________________
```

"Q?" entered as verification

```
SFCS                  STANDARD FILING UNIT CASCADE SUMMARY       06/06/01 08:30
 CASE: 8000361485                                WORKER: XCTG04    XCTG04 P KIERN

                      PAYMENT   PAYMENT     AG     ELIG      AG REASON CODES
  S  RUN  CAT   SEQ   BEG DATE  END DATE  STATUS  STATUS  S RSN1  S RSN2  S RSN3
  _  01   CC    01    07 01 01              PE      P
         CC    01    06 01 01  06 30 01    PE      P
  _  01   FS    01    07 01 01              DE      F      _ 15
         FS    01    06 01 01  06 30 01    OP      S      _ 154
  _  01   WW C  01    07 01 01              PE      P
     01   BC Z  01    07 01 01              DE      F      _ 054
  _  01   MA R  01    07 01 01              CL      F      _ 054
```

CC & W2 pend

"?" Example: The following case example illustrates when a "?" is entered on a Non Mandatory field for Family MA. The case is requesting CC, FS, MA and W2. CC, FS, and W2 pend. MA passes and should be confirmed.

```
AALA                                LIQUID ASSETS                 06/04/01 16:08
 CASE: 4000368044                          WORKER: XCTG04    XCTG04 P KIERN
 LAST UPDATED:                        CASE STATUS: OPEN    CASE MODE: ONGOING

 LIQUID ASSET TYPES:

 NUM: 01 OWNER NAME:                                        SSN:

  DC: __ BEGIN MMYY: 0601  END MMYY: ____
 SEQ                                  JOINTLY OWNED  AVAILABLE     BURIAL
 NUM:     TYPE: ch             VR: ?    (Y/N/?): n    (Y/N/?): y   (Y/N/?): n
  ASSET AMOUNT:  500_____      VR: ?_  INDEPENDENCE ACCOUNT? (Y/N): _
                               IND. ACCT REGISTRATION DATE:  __ __ ____
     ACCOUNT NUMBER: _________      PRE-IND. ACCT BAL AMOUNT:     _________
   INSTITUTION NAME: ____________________________
 INSTITUTION ADDRESS: ____________________________
                      ____________________________
               CITY: _______________ STATE: __
 -------------------------------INDIVIDUALS---
  01 NICE  W (PP )    02 DAUGH W (DAU)

 PFKEYS:    20=AAJO
```

"?" entered in both verifiction fields.

```
SFCS                  STANDARD FILING UNIT CASCADE SUMMARY       06/04/01 16:10
 CASE: 4000368044                                WORKER: XCTG04    XCTG04 P KIERN

                      PAYMENT   PAYMENT     AG     ELIG      AG REASON CODES
  S  RUN  CAT   SEQ   BEG DATE  END DATE  STATUS  STATUS  S RSN1  S RSN2  S RSN3
  _  01   CC    01    07 01 01              OP      S
         CC    01    06 01 01  06 30 01    OP      S
  _  01   FS    01    07 01 01              PE      P
         FS    01    06 01 01  06 30 01    PE      P
  _  01   WW C  01    07 01 01              PE      P
         WW C  01    06 01 01  06 30 01    PE      P
  _  01   MA R  01    07 01 01              OP      S
```

FS and W2 pend, MA passes, CC passes (No asset test)

"QV" Example: This is the same case with a QV entered in the verification field. CC,FS, and W2 fail. BC and HS pass and should be confirmed because assets are not looked at for these types of family MA.

```
AALA                                  LIQUID ASSETS                 06/04/01 16:13
 CASE: 4000368044                                WORKER: XCTG04    XCTG04 P KIERN
 LAST UPDATED: 06 04 01                   CASE STATUS: OPEN    CASE MODE: ONGOING

 LIQUID ASSET TYPES:

 NUM: 01 OWNER NAME: NICE              WINTERDAY           SSN: 018 98 0907

  DC: __ BEGIN MMYY: 0601  END MMYY: ____
 SEQ                                    JOINTLY OWNED  AVAILABLE     BURIAL
 NUM: 001 TYPE: CH CHECKING AC  VR: qv   (Y/N/?): N    (Y/N/?): Y   (Y/N/?): N
  ASSET AMOUNT:    1500.00      VR: qv  INDEPENDENCE ACCOUNT? (Y/N): N
                                        I    ACCT REGISTRATION DATE:  __ __ ____
     ACCOUNT NUMBER: __________         PRE    ACCT BAL AMOUNT:      __________
   INSTITUTION NAME: _____________________
 INSTITUTION ADDRESS: _____________________
                      _____________________________
               CITY: _______________ STATE: __ ZIP: __________
 --------------------------------INDIVIDUALS-------------------------------------
  01 NICE  W (PP )    02 DAUGH W (DAU)
```

"QV" entered as verif.

```
SFCS                  STANDARD FILING UNIT CASCADE SUMMARY       06/04/01 16:15
 CASE: 4000368044                              WORKER: XCTG04    XCTG04 P KIERN

                      PAYMENT   PAYMENT     AG     ELIG      AG REASON CODES
  S  RUN  CAT   SEQ  BEG DATE  END DATE  STATUS  STATUS  S RSN1  S RSN2  S RSN3
  _  01   CC    01   07 01 01              OP      S
         CC    01   06 01 01  06 30 01     OP      S
  _  01   FS    01   07 01 01              DE      F      _ 112
         FS    01   06 01 01  06 30 01     DE      F      _ 112
  _  01   WW C  01   07 01 01              DE      F      _ 112
         WW C  01   06 01 01  06 30 01     DE      F      _ 112
  _  01   MA R  01   07 01 01              DE      F      _ 013   _ 014   _ 112
  _  01   MHSC  01   07 01 01              CL      F      _ 350
  _  02   MAOR  01   07 01 01              DE      F      014   _ 112   _ 024
  _  02   MHSC  01   07 01 01              CL      F      _
  _  03   MHSC  01   07 01 01              OP      S
  _  04   BC    01   07 01 01              OP      S
```

MA R fails, BC and HS pass as no assets are checked for these subprograms.

"NV" Example: This is an EBD case with a "NV" entered in a Mandatory MA verification field. MA fails and should be confirmed.

```
ANDI                        DISABILITY                              06/05/01 08:45
 CASE: 2000389228                              WORKER: XCTG04    XCTG04 P KIERN
 LAST UPDATED: 06 05 01                    CASE STATUS: PENDING CASE MODE: INTAKE

 NUM: 01 NAME: IMA               RAINYDAY            SSN:  32 90 8010
  DC: __ BEGIN MMYY: 0601 END MMYY: ____

 HAS INDIVIDUAL BEEN ESTABLISHED BLIND BY DDB?                (Y/N): N   VR: __
 HAS INDIVIDUAL BEEN ESTABLISHED DISABLED BY DDB?             (Y/N): Y   VR: nv
 PRESUMPTIVE DISABILITY?    (Y/N): _   PRESUMPTIVE DISABILITY TYPE: __  VR: __
 DATE SENT TO DDB: __ __ __                    DATE RECD FROM DDB : __ __ __

       ONSET DATE: 06 05 01                              REVIEW DATE: __ __ __

 FS DISABILITY?   (Y/N): N  VR: __
 IF ELDERLY/DISABLED, UNABLE TO P/P MEALS DUE TO DISABILITY? (Y/N): _
 IS INDIVIDUAL INCAPABLE OF OBTAINING GAINFUL EMPLOYMENT?    (Y/N): _
 IS A HH MEMBER NEEDED TO CARE FOR THIS PERSON? (Y/N): N HIS/HER SL N
---------------------------------INDIVIDUALS-----------------------------------
  01 IMA   R (PP )
```

"NV" entered as verification.

```
SFCS                   STANDARD FILING UNIT CASCADE SUMMARY       06/05/01 08:45
 CASE: 2000389228                              WORKER: XCTG04    XCTG04 P KIERN

                      PAYMENT   PAYMENT     AG     ELIG      AG REASON CODES
  S  RUN  CAT   SEQ  BEG DATE  END DATE  STATUS  STATUS  S RSN1  S RSN2  S RSN3
     01   CC Z  01   07 01 01              DE      F      _ 054
          CC Z  01   06 01 01  06 30 01    DE      F      _ 054
     01   FS Z  01   07 01 01              DE      F      _ 054
          FS Z  01   06 05 01  06 30 01    DE      F      _ 054
     01   WW Z  01   07 01 01              DE      F      _ 054
          WW Z  01   06 05 01  06 30 01    DE      F      _ 054
  _  01   MS    01   07 01 01              DE      F      _ 112
          MS    01   06 01 01  06 30 01    DE      F      _ 112
     02   BC Z  01   07 01 01              DE      F      _ 054
          BC Z  01   06 01 01  06 30 01    DE      F      _ 054
```

MA fails.

ATTACHMENTS

The forms attached beyond attachment #3 are only facsimiles and may vary from the real versions of the forms.

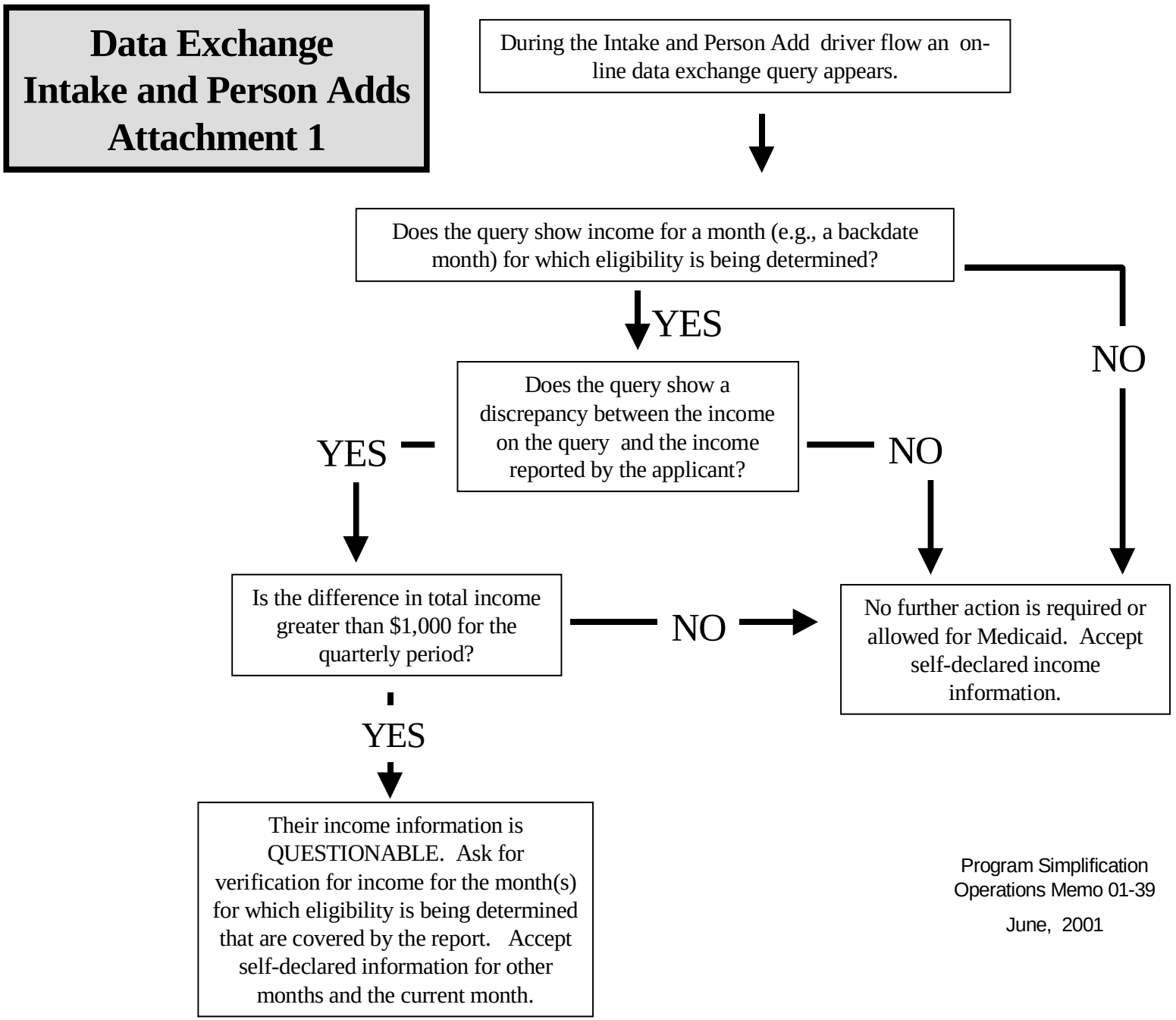
CONTACT

DES CARES Information & Problem Resolution Center

Email: carpolcc@dwd.state.wi.us
Telephone: 608-261-6317 (Option #1)
Fax: 608-266-8358

NOTE: Email contacts are preferred. Thank you.

Data Exchange Intake and Person Adds Attachment 1



Program Simplification
Operations Memo 01-39

June, 2001

Data Exchange Ongoing Attachment 2

Worker gets an alert saying that a DX report contains one or more of his/her cases.

Worker sees a DXBM with a match report listed. Worker then goes to that report and finds one of his/her cases on the report.

On his/her own initiative, worker checks the on-line DX Query for this case.

The client's information for the past period is QUESTIONABLE. Ask client for verification of income for the period covered in the report.

YES

Is the difference in total income greater than $1,000 for the quarterly period and was anyone in the case receiving Medicaid during those months?

NO

Using the client verified information for that past period worker uses simulation to determine if there was an overpayment for that period. Was there an overpayment?

NO

No further action is required or allowed for Medicaid. Continue to use self-declared income information for this case.

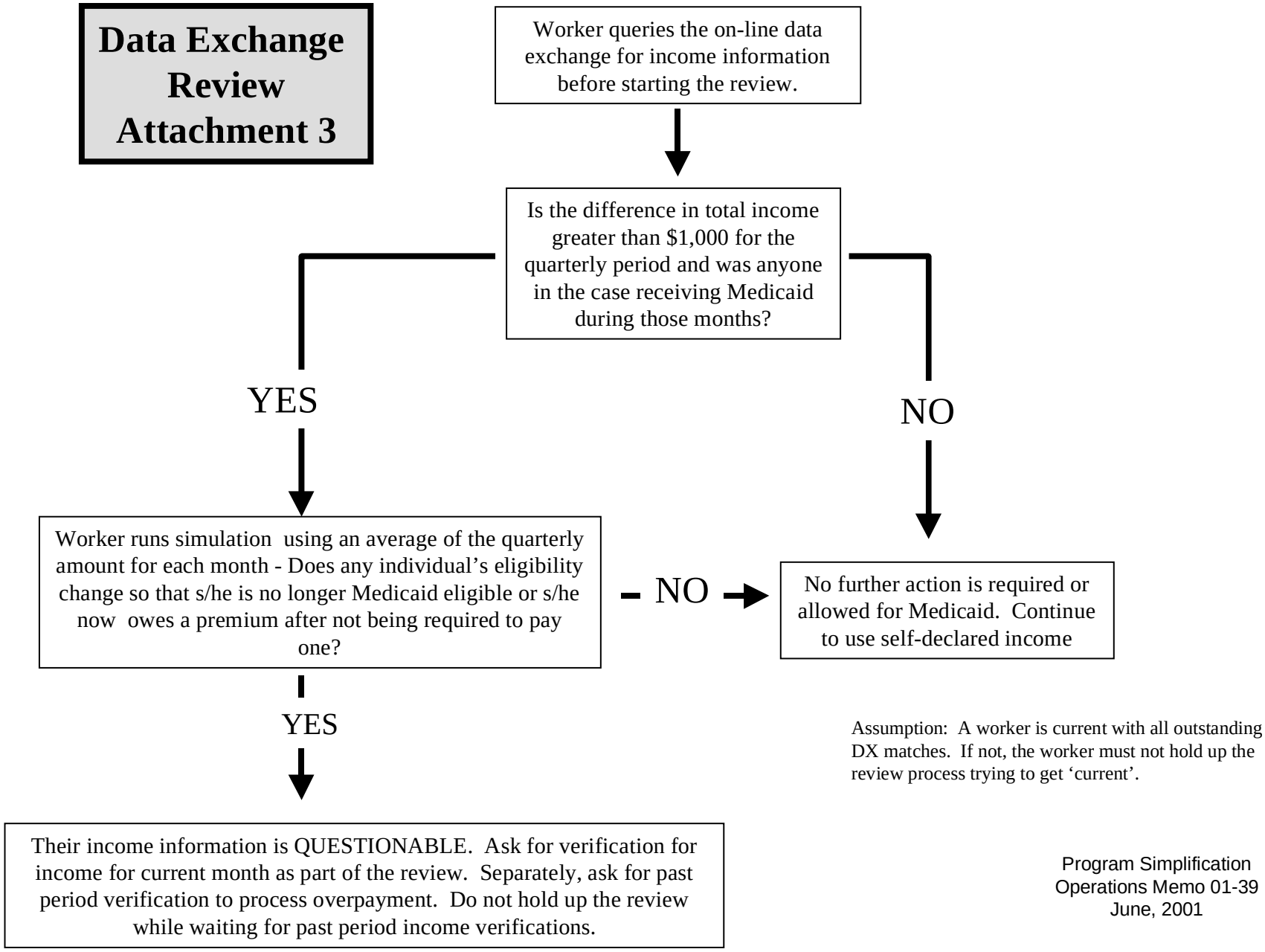
YES

The existence of an overpayment means that there was a significant eligibility change. Process the overpayment. The current month's income is now QUESTIONABLE. The worker must request verification of current month's income.

Assumption: $1,000 tolerance level exists for the reports. A case doesn't show up on the report if income is within that tolerance level.

Program Simplification
Operations Memo 01-39
June, 2001

Data Exchange Review Attachment 3



Assumption: A worker is current with all outstanding DX matches. If not, the worker must not hold up the review process trying to get 'current'.

Program Simplification
Operations Memo 01-39
June, 2001

STATE OF WISCONSIN
DEPARTMENT OF WORKFORCE DEVELOPMENT
Division of Workforce Solutions

INFORMATION SHEET FOR THE WISCONSIN FAMILY MEDICAID/BADGERCARE APPLICATION AND REVIEW FORM

This is a Medicaid application form only for families with children under age 19 and pregnant women. For help of any kind with Medicaid or BadgerCare, please call the statewide hotline at 1-800-362-3002.

This is not an application for food stamps, child care, or W-2. If you are interested in applying for these programs of assistance you must contact your local county/tribal social or human services department, or your W-2 agency. These programs provide persons or families help with the costs of food, the costs of child care, or finding a job as part of Wisconsin Works (W-2).

Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m)].

HOW TO USE THIS FORM:

1. Complete the Family Medicaid/BadgerCare Application and Review Form with current information using **ink**.
2. **Do not write in the shaded section.**
3. Enter information about all the people that live with you. If you do not have enough space on the form for everyone that lives with you or for writing in your income and assets, please fill out a second copy of the application form.
4. You only have to give a Social Security Number and U.S. citizenship status for each person that is applying for Medicaid or BadgerCare. If someone in your household is not applying for Medicaid/ BadgerCare you do not need to provide their Social Security number or U.S. citizenship status. For only those people that are applying this information may be submitted to the Immigration and Naturalization Service (INS) for verification.
5. For the income and assets section, fill in each space with a 0 (zero) or NA (Not Applicable) if you do not have any of that type of income or asset.
6. If you are pregnant, please include with your application a signed and dated note from your doctor or another health care professional saying that you are pregnant and identifying your expected due date.
7. Complete this application as fully as you can. If it is not complete when you send it in, there may be a delay in receiving Medicaid benefits. If the application is not complete or if you answered yes to any of the first three questions on the application form, a worker may contact you for more information.

NOTE: If you need help filling out this application, contact your local county/tribal social or human services department. You may even be able to schedule an appointment to answer the questions in person or over the phone.

Important information:

- Your application date is the date we receive this signed application form. We will mail you a decision within 30 days about your eligibility for Medicaid/BadgerCare.
- It is important to apply as soon as you can because if you are eligible, your benefits will be based on your application date. If you are eligible, you may be able to get Medicaid benefits for up to three months before your application date if all the needed information is collected for the backdated months. BadgerCare can begin no earlier than the first of the month in the month of application. If you are interested in help paying for health care for any of the past three months (backdating), please check yes next to the second question on the application form.
- Learn about your rights and responsibilities in the "**Rights and Responsibilities**" pamphlet. If you do not have a pamphlet, please contact us for one. If you have any questions about your rights and responsibilities, ask us about them.
- If you are found eligible for Medicaid/BadgerCare, you will need to complete a review every 12 months so we can decide if you are still eligible for assistance.

RIGHTS AND RESPONSIBILITIES (Please read this before signing the application)

Your signature on the application means that you understand and acknowledge that the county or tribal department of social/human services, county W-2 agency and the state Department of Health and Family Services is authorized to request any information that is appropriate and necessary for the proper administration of the Medicaid program authorized under Wisconsin Law.

Any person, including any financial institution, credit reporting agency, employer, or educational institution, is authorized to release this information, according to Wisconsin Statute S. 46.25 (2m): "The department may request from any person any information it determines appropriate and necessary for the administration of this section, ss. 49.19, 49.45 through 49.47 and programs carrying out the purposes. Any person in this state shall provide this information within seven (7) days after receiving a request under this subsection."

Checklist

☐ Is the application complete? For the income and assets section, fill in each space with a 0 (zeros) or NA (Not Applicable) if you do not have any of that type of income or asset.

☐ If you are pregnant, did you include a signed and dated note from a doctor or other health care professional saying that you are pregnant and the due date?

☐ Did you read the Rights and Responsibilities section (see above)?

☐ Did you sign and date the application form?

☐ Send the application form to the address in the box below.

NOTE: A worker may contact you by phone or mail if s/he needs more information or verification. For example, s/he may ask to see a pay stub to verify your income. S/he is only allowed to ask for additional verification if there is missing, conflicting or vague information and this information would affect your Medicaid eligibility decision.

When you have finished the application, send it to the address listed below.

Other Program Information:

If you are interested in services for veterans, call 1-800-947-8347 (WIS-VETS), or contact your county Veteran Service Officer.

For information about the Women, Infants, and Children (WIC) Nutrition Program, call 1-800-722-2295.

For information about services for women, children and families, contact the Wisconsin Maternal Child Health Hotline at 1-800-722-2295.

STATE OF WISCONSIN
DEPARTMENT OF WORKFORCE DEVELOPMENT
Division of Workforce Solutions

Wisconsin Family Medicaid/BadgerCare Application and Review

Do you want Food Stamp assistance for you and your family? ☐ Yes ☐ No If yes, please see the instruction sheet for information on applying for Food Stamps and other programs.

Are you interested in help paying for health care for any of the past three months? ☐ Yes ☐ No
Is there anyone blind or disabled in your household? ☐ Yes ☐ No
PLEASE USE INK

Name of the person providing information.	Do you live in the household? ☐ Yes ☐ No	Date Received	Case Number
Circle the language you want the notices printed in. English Spanish	If you are applying for someone else, write in the person's name.	Your relationship to that person.	

If you are completing this application for someone else, answer the rest of the questions as if you were that person.

Address	City	State	Zip Code	Phone Number ( )
				We ask you to voluntarily tell us your race or ethnic background. This information will not be used to determine your eligibility. ☐ Caucasian ☐ American Indian/Alaska Native ☐ Hispanic ☐ Black ☐ Asian or Pacific Islander
Mailing address (only if different from where you live)	City	State	Zip Code	

General Information

	Write in the names of all persons **now** living with you and those person(s) who are temporarily away from your home but will return. **Circle the number at the left of those members who you are requesting assistance for.** **First Name Middle Initial Last Name**	**** Social Security Number**	**Date of Birth**	Sex M/F	**Marital Status** (see codes below)	**Do you attend school?** F-Full time P-Part time	**** Are you a U.S. Citizen? Yes(Y)/ No(N)**	****** If **not** a U.S. citizen: **Date of entry to U.S. &** your **alien registration number.**	Relationship to person on line 1	Relationship to person on line 2
1	Name of person applying for aid			M F		F P	Y N	Mo/Day/Yr Number:		
2	Your husband/wife, or father/mother of your children			M F		F P	Y N	Mo/Day/Yr Number:		
3				M F		F P	Y N	Mo/Day/Yr Number:		
4				M F		F P	Y N	Mo/Day/Yr Number:		
5				M F		F P	Y N	Mo/Day/Yr Number:		

***MARITAL STATUS CODES**: A-Annulled, D-Divorced, LS-Legally Separated, M- Married, S-Separated, N-Never Married, W-Widowed*

Absent Parent Information

Do any children have a natural or adoptive mother or father who is not living at home? ☐ Yes ☐ No If yes, provide the following information about the absent parent(s).

Absent parent's name First Last	**Social Security Number**	**Date of birth**	**Name of children**	**Relationship to Child**	**Reason for absent parent's absence**	**Date absent parent left the household.**	**Date of last contact with the absent parent**	**If there is a court order of divorce or paternity write in the information below**
				Mother Father				Case Number: County: State:

DES-12277 (R. 2/2001)

****** Not required for non-applicants

Employment

I am (we are) working (including self-employment). ☐ Yes ☐ No If yes, list person(s) below. Is anyone listed below a migrant worker? ☐ Yes ☐ No

Person	**Employer**	**Date employment began**	**Pay period (weekly, bi-weekly)**	# of hours/pay period	$/hour	Gross earnings

Income/Assets

List all people that this applies to, as well as the other information asked for. Please add a second sheet if more room is needed.

	Yes No	Owner's Name	Value	Type (* required, see below)	Owner's Name	Value	Type
Cash	☐ ☐		$			$	
Checking Account	☐ ☐		$			$	
Savings Account	☐ ☐		$			$	
*Assets	☐ ☐		$	*		$	
*Does anyone have unearned income?	☐ ☐		$	*		$	
Life insurance	☐ ☐		$			$	
Vehicles	☐ ☐		$			$	
*Other income	☐ ☐		$	*		$	
*Other Assets	☐ ☐		$	*		$	

***ASSETS**: Certificate of deposit, Trust Funds/Estate, Stocks or Bonds, IRA, Keogh Plan or Other Tax Shelter, Christmas Club, Other savings or investments (describe)
***UNEARNED INCOME**: Alimony/Maintenance, Charity, Child Support, Disability/Sick pay, Interest/Dividends, Pension/Retirement, Worker's Comp, Money from property sold, Money from another person, Social Security, SSI, Veteran's Benefits, Unemployment Insurance, Other (describe).

Miscellaneous

	Yes No	Person			
Does any person have medical insurance coverage?	☐ ☐	Policy Holder Who is covered	Insurance Company	Policy Number	Date coverage began
Does anyone pay for child care or adult care so they can work, look for work, or go to school or training?	☐ ☐	Who pays for child care	Who do you pay	Who is it for	Amount
Does anyone pay child support?	☐ ☐	Who pays the child support	Who receives the child support payments		Amount

Are any members of your household pregnant? ☐ Yes ☐ No If yes, list person(s) below along with the due date and information on multiple births.

NAME	DUE DATE	ARE MULTIPLE BIRTHS EXPECTED?
		☐ NO ☐ YES If yes, write in how many babies are expected

Please read the Rights and Responsibilities section on the Information Sheet for the Medicaid/BadgerCare Application form before signing.

I understand the questions and statements on this application form. I understand the penalties for giving false information or breaking the rules. I certify, under penalty of perjury and false swearing, that all my answers are correct and complete to the best of my knowledge, including information provided about the citizenship or alien status of each household member. I understand and agree to provide documents to prove what I have said. I understand that the agency may contact other persons or organizations to obtain the necessary proof of my eligibility and level of benefits.

Signature of Primary Person	Date	Signature of Other Adult	Date

STATE OF WISCONSIN
DEPARTMENT OF WORKFORCE DEVELOPMENT
Division of Workforce Solutions

INFORMACIÓN PARA EL FORMULARIO DE SOLICITUD Y REVISIÓN DE FAMILY MEDICAID Y BADGERCARE DEL ESTADO DE WISCONSIN

(INFORMATION FOR THE WISCONSIN FAMILY MEDICAID/BADGERCARE APPLICATION AND REVIEW FORM)

Este es un formulario de solicitud de Medicaid solamente para familias con niños menores de 19 años de edad y mujeres embarazadas. Para obtener ayuda de cualquier clase sobre Medicaid o BadgerCare, sírvase llamar a la línea directa del estado entero al 1-800-362-3002.

Esta no es una solicitud para cupones de alimentos (food stamps), cuidado de menores ni W-2. Si le interesa solicitar alguno de estos programas de asistencia debe ponerse en contacto con el departamento local de servicios sociales o humanos de su condado o tribu o con la agencia W-2 que le corresponde. Estos programas proporcionan ayuda a individuos o familias con los gastos de alimentos, de cuidado de menores o para encontrar un trabajo, como parte de Wisconsin Works (W-2).

La información personal que usted proporcione se puede usar para fines secundarios. [Privacy Law, s. 15.04 (1)(m)].

CÓMO USAR ESTE FORMULARIO:

1. Llene el formulario de solicitud y revisión de Family Medicaid/BadgerCare, con información actualizada. Use **tinta**.
2. **No escriba en la sección sombreada.**
3. Proporcione información acerca de todas las personas que viven con usted. Si no hay espacio suficiente para todos los miembros de su casa o para proporcionar información financiera en este formulario, sírvase completar una segunda copia del formulario de solicitud.
4. Solamente tiene que proporcionar el número de seguro social y el estado de residencia en E.U.A. (ciudadanía, etc.) para cada persona que solicita beneficios de Medicaid o BadgerCare. Si un miembro de su casa no solicita Medicaid/BadgerCare, no es necesario proporcionar su número de seguro social ni su estado de residencia en E.U.A. Solamente para las personas que solicitan, es posible que se proporcione esta información al Servicio de Inmigración y Naturalización para verificación.
5. Para la sección financiera, rellene cada espacio con un 0 (cero) o NA (No aplicable) si no tiene ese tipo de ingresos o bienes.
6. Si usted está embarazada, favor de incluir con la solicitud una nota con la fecha y firma de su doctor u otro profesional médico para verificar el embarazo e identificar la supuesta fecha de nacimiento.
7. Complete esta solicitud lo mejor que pueda. Si no está completa cuando la envíe, podrían retrasarse sus beneficios de Medicaid. Si la solicitud no está completa o si usted contestó afirmativamente cualquiera de las primeras tres preguntas del formulario, alguien se pondrá en contacto con usted para obtener más información.

NOTA: Si necesita ayuda para llenar esta solicitud póngase en contacto con el departamento local de servicios sociales o humanos de su condado o tribu. Es posible que pueda hacer una cita para obtener respuestas a sus preguntas en persona o por teléfono.

Información Importante:

- La fecha de su solicitud es la fecha en que recibimos este formulario de solicitud firmado. En un plazo de 30 días le enviaremos por escrito una decisión sobre su elegibilidad para Medicaid/BadgerCare.
- Es importante hacer la solicitud tan pronto como pueda porque si es elegible, sus beneficios se basarán en la fecha de su solicitud. Los beneficios de Medicaid para personas elegibles pueden ser retroactivos hasta tres meses antes de la fecha de su solicitud si se satisfacen todos los requisitos de elegibilidad para los meses en retroactividad. BadgerCare no empieza antes que el día primero del mes de la solicitud. Si le interesa recibir ayuda para pagar el cuidado médico para cualquiera de los tres meses anteriores a esta solicitud, sírvase contestar sí a la segunda pregunta en el formulario de solicitud.
- Aprenda acerca de sus derechos y responsabilidades en el folleto "**Derechos y Responsabilidades**". Si no tiene este folleto, sírvase avisarnos. Si tiene cualquier pregunta acerca de sus derechos y responsabilidades, pregúntenos.
- Si es elegible para Medicaid/BadgerCare, necesitará completar una revisión cada 12 meses para que podamos decidir si aún tiene derecho a recibir asistencia.

DERECHOS Y RESPONSABILIDADES (Sírvase leer esto antes de firmar la solicitud)

Su firma en la solicitud significa que entiende y confirma que el departamento de servicios sociales y humanos del condado o tribu, la agencia W-2 del condado y el departamento de salud y servicios familiares del estado están autorizados para solicitar cualquier información que sea apropiada y necesaria para la administración correcta del programa Medicaid autorizado bajo la Ley de Wisconsin.

Cualquier persona , incluyendo cualquier institución financiera, agencia de reporte de crédito, patrón, o institución educativa está autorizada para liberar esta información de acuerdo con la Ley Escrita S. 46.25 (2m) de Wisconsin: "El departamento puede solicitar a cualquier persona cualquier información si determina que es apropiada y necesaria para la administración de esta sección ss. 49.19.49.45 a 49.47 y los programas que llevan a cabo los fines. Cualquier persona en este estado proporcionará esta información en un plazo de siete días después de recibirse una solicitud bajo esta subsección".

Lista de Comprobación

- ☐ ¿Está completa la solicitud? Para la sección financiera, rellene cada espacio con un 0 (cero) o NA (No aplicable) si no tiene ese tipo de ingresos o bienes.
- ☐ Si está embarazada, ¿ha incluido una nota con la fecha y firma de un médico u otro profesional de salud para verificar su embarazo y la supuesta fecha de nacimiento?
- ☐ ¿Leyó la sección de Derechos y Responsabilidades (véase arriba)?
- ☐ ¿Firmó el formulario de solicitud y le puso la fecha?
- ☐ Envíe el formulario de solicitud a la dirección que aparece en el cuadro a continuación.

NOTA: Es posible que alguien se ponga en contacto con usted por teléfono o correo si necesita más información o verificación. Por ejemplo, es posible que le pida una copia de su talonario de cheque para verificar su salario. Solamente se permite solicitar verificación adicional si falta información, la información es contradictoria o indeterminada y si dicha información afectaría la decisión de su elegibilidad para recibir beneficios de Medicaid.

Al terminar de llenar la solicitud, envíala a la dirección indicada abajo.

Información de otros programas:

Si está interesado en los servicios para veteranos, llame al 1-800-947-8347 (WIS-VETS), o póngase en contacto con el oficial del Servicio a Veteranos de su condado.

Para obtener información sobre el Programa de Nutrición (WIC) para Mujeres, Bebés y Niños , llame al 1-800-722-2295.

Para obtener información sobre los servicios para mujeres, niños, y familias, llame a la línea directa de Wisconsin Maternal Child Health al 1-800-722-2295.

STATE OF WISCONSIN
DEPARTMENT OF WORKFORCE DEVELOPMENT
Division of Workforce Solutions

Solicitud y Revisión para Family Medicaid/BadgerCare de Wisconsin

(Wisconsin Family Medicaid/BadgerCare Application and Review)

¿Desea asistencia con Estampillas por Alimentos para usted y su familia? ☐ Si ☐ No En caso afirmativo, sírvase consultar la hoja de instrucciones para solicitar las estampillas por alimentos y otros programas.

¿Le interesa la ayuda para pagar atención médica en cualquiera de los tres meses pasados? ☐ Si ☐ No

¿Hay alguien invidente o inválido en su casa? ☐ Si ☐ No

SÍRVASE UTILIZAR TINTA

Nombre de la persona que da la información.	¿Vive usted en la casa? ☐ Si ☐ No	Fecha de recepción	Número de caso

Circule el idioma en que desea los avisos. Inglés Español	Si está haciendo la solicitud a nombre de otra persona, escriba el nombre de esa persona.	Su parentesco con esa persona.

Si está llenando esta solicitud por alguien más, conteste el resto de las preguntas como si usted fuera esa persona.

Domicilio	Ciudad	Estado	Código postal	Número de teléfono ( )
Dirección para correo (sólo si es diferente de donde vive)	Ciudad	Estado	Código postal	Le pedimos que voluntariamente nos diga su raza o antecedente étnico. Esta información no se usará para determinar su derecho. ☐ Caucásico ☐ Indio Americano /Nativo de Alaska ☐ Hispano ☐ Negro ☐ Asiático o Isleño del Pacífico

Información General

	Escriba los nombres de todas las personas que **ahora** viven con usted y de aquella(s) persona(s) temporalmente lejos de su casa pero que regresarán. **Circule el número a la izquierda de los miembros para quienes solicita ayuda**. ***NOMBRE INICIAL APELLIDO***	**** Número de seguro social**	**Fecha de nacimiento**	Sexo M/F	**Esta-do civil** (ver claves abajo)	**¿Va a la escuela?** F-Todo el tiempo P-Parte	**** Es ciudadano de los EU? Si(Y)/ No(N)**	****** Si **no** es ciudadano: **Fecha de entrada a los EU y su número de registro de extranjero.**	**Parentesco con la persona en** línea 1	línea 2
1	Nombre de la persona que solicita ayuda			M F		F P	Y N	Mes/Día/Año Número:		
2	Su esposo/esposa, o padre/madre de sus hijos			M F		F P	Y N	Mes/Día/Año Número:		
3				M F		F P	Y N	Mes/Día/Año Número:		
4				M F		F P	Y N	Mes/Día/Año Número:		
5				M F		F P	Y N	Mes/Día/Año Número:		

CLAVES DE ESTADO CIVIL: A- Anulado, D- Divorciado, LS- Separado legalmente, M- Casado, S- Separado, N- Soltero, W- Viudo

Información de padres ausentes

¿Algún niño tiene madre o padre natural o adoptivo que no viva en la casa? ☐ Si ☐ No En caso afirmativo, proporcione la siguiente información de padres ausentes.

Nombre de padres ausentes Nombre Apellido	**Número de seguro social**	**Fecha de nacimiento**	**Nombre del niño**	**Parentesco con el niño**	**Razón de la ausencia de padres ausentes**	**Fecha en que el padre ausente dejó la casa**	**Fecha del último contacto con el padre ausente**	**Si hay una orden judicial de divorcio o paternidad escriba la información abajo**
				Madre Padre				Número de caso: Condado: Estado:

DES-12470-S (N. 2/2001)

****** No requerido para no solicitantes

Empleo

Estoy (estamos) trabajando (incluir autoempleo). ☐ Si ☐ No En caso afirmativo, enumerar a la(s) persona(s) abajo.
¿Es alguno de los enumerados trabajador inmigrante? ☐ Si ☐ No

Persona	Patrón	Fecha de inicio del empleo	Período de pago (semanal, quincenal)	# de horas/período de pago	$/hora	Ingresos brutos

Ingresos/Bienes

Enumere todas las personas a quienes corresponda, así como la otra información que se pide. Sírvase agregar una segunda hoja si es necesario.

	Si No	Nombre del propietario	Valor	Tipo (* necesario, ver abajo)	Nombre del dueño	Valor	Tipo
Efectivo	☐ ☐		$			$	
Cuenta de cheques	☐ ☐		$			$	
Cuenta de ahorros	☐ ☐		$			$	
*Bienes	☐ ☐		$	*		$	
*Alguien tiene ingreso no devengado?	☐ ☐		$	*		$	
Seguro de vida	☐ ☐		$			$	
Vehículos	☐ ☐		$			$	
*Otros ingresos	☐ ☐		$	*		$	
*Otros bienes	☐ ☐		$	*		$	

***BIENES**: Certificados de depósito, Fondos/Propiedad en fideicomiso, Acciones o bonos, IRA, Keogh Plan o algún otro beneficio fiscal, Club de Navidad, Otros ahorros o inversiones (describir)

***INGRESOS NO GANADOS**: Pensión alimentaria/manutención, caridad, manutención de menor, incapacidad/licencia por enfermedad, intereses/dividendos, pensión/retiro, compensación al trabajador, dinero por propiedad vendida, dinero de otra persona, seguro social, SSI, beneficios de veterano, seguro por desempleo, otro (describir).

Misceláneos

	Si No	Persona			
¿Alguien tiene cobertrura por seguro médico?	☐ ☐	Titular Quien está cubierto	Compañía aseguradora	Número de póliza	Fecha en que inició la cobertura
¿Alguien paga por atención a menor o adulto para que puedan trabajar, buscar trabajo o ir a la escuela o a capacitación?	☐ ☐	Quien paga por atención a menor	A quién le paga	Para quién es	Cantidad
¿Alguien paga manutención de menor?	☐ ☐	Quién paga manutención de menor	Quien recibe los pagos de manutención de menor		Cantidad

Algún miembro de su familia está embarazada? ☐ Si ☐ No En caso afirmativo, enumere a la(s) persona(s) junto con la fecha esperada en información de nacimientos múltiples.

NOMBRE	FECHA ESPERADA	¿SE ESPERAN NACIMIENTOS MÚLTIPLES?
		☐ NO ☐ SI En caso afirmativo, excriba cuántos bebés se esperan

Sírvase leer la sección sobre Derechos y Responsabilidades en la Hoja de Información sobre la solicitud de asistencia médica y atención a los naturales de Wisconsin antes de firmar.

Entiendo las preguntas y declaraciones de esta forma de solicitud. Entiendo la pena por dar información falsa o romper las reglas. Certifico, bajo pena por perjurio y falso juramento, que a mi mejor entender todas mis respuestas son correctas y completas, incluyendo la información sobre la nacionalidad o el estado de extranjero de cada miembro de la casa. Entiendo y estoy de acuerdo en proporcionar los documentos que prueben lo que he dicho. Entiendo que la oficina puede contactar a otras personas u organizaciones para obtener la prueba necesaria de que soy elegible y el nivel de beneficios.

Firma de la persona principal	Fecha	Firma de otro adulto	Fecha